STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366195	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, policy review, and interview, the facility failed to ensure significant weight gain was timely investigated and/or addressed for a resident with congestive heart failure (CHF). This affected one (Resident #43) of three residents reviewed for dietary assistance with meals. Findings include: Review of Resident #43's open medical record revealed an admitted [DATE]. Diagnoses included anxiety disorder, major depressive disorder, dementia, morbid obesity, peripheral vascular disease, lymphedema, senile degeneration of the brain and chronic congestive heart failure. A nutrition assessment dated [DATE] indicated Resident #43 ate independently and was receiving a no added sodium diet. Intakes were good at approximately 75%. Resident #43 was assessed as morbidly obese with no significant weight changes within the prior six months. A physician progress note for a visit from 12/07/24 revealed Resident #43 had significant lower extremity edema and a work up for aortic stenosis had been delayed. A cardiology consultation was requested but there may be a delay as the resident had not seen a cardiologist since 2021. Interventions included awaiting cardiology consultation for further evaluation and monitoring for signs of decompensation. If decompensation occurred the physician would consider inpatient admission through the emergency room (ER) for expedited care. Management with lasix (diuretic) 20 milligrams (mg) every day for edema would continue. Morbid obesity might be contributing to her other health issues, including lower extremity edema and difficulty in managing her cardiovascular conditions. The physician documented a weight of 314 pounds which was about the same as her admission weight of 311 pounds. A nursing note dated 12/10/24 at 9:17 A.M. indicated Resident #43's daughter and sister were present in the facility and requested Resident #43 be sent to the hospital for shortness of breath. The physician approved the request. A nursing note dated 12/11/24 at 10:51 indicated Resident #43 was admitted to the hospital with a diagnosis of heart failure. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43 returned to the facility 12/15/24. Discharge paperwork revealed a resident teaching tool regarding CHF and indicated a daily weight was recommended. However, there was no order for daily weights. There was no indication the recommendation for daily weights for Resident #43 was discussed with the physician. A physician visit note dated 12/16/24 at 4:36 P.M. indicated concerns with bilateral lower extremity edema and redness. The physician indicated Resident #43 had been sent to the hospital where her diuretic was increased. A weight recorded on 12/17/24 revealed a weight of 348.2 pounds. A dietary note dated 12/20/24 at 10:16 A.M. indicated a significant weight gain was noted and a re-weight was requested. On 12/23/24 a weight of 341.6 pounds was recorded. During an interview of the Director of Nursing (DON) on 12/24/24 at 6:33 A.M., the Director of Nursing (DON) revealed she reviewed all weights. When a weight change of three to five pounds was noted from a previous weight, residents were automatically re-weighed prior to the weight being documented in the electronic health record. Once a re-weight was confirmed, if a significant change in weight was identified residents were discussed in the nutrition meetings held weekly. The dietitian reviewed the weights and made any recommendations by Friday every week. If a re-weight was requested, it was obtained the following Monday. The DON indicated the weight was placed into the electronic health record which the dietitian had access to and the weight would flag. The DON indicated she was uncertain how often the dietitian got into the system to review the weights. At 10:03 A.M. the DON stated every resident who went to the hospital with a diagnosis of CHF returned with the resident education form with recommendations for daily weights. This had been discussed with the physician previously who agreed daily weights were not required and it was sufficient to obtain weekly weights. Resident #43's needs for increased monitoring of weight had not been discussed with the physician even though the facility had confirmed a weight gain of 34 pounds in a 13 day period. The facility's policy which indicated if a weight was verified nursing would notify the dietitian was reviewed with the DON. The DON verified after staff confirmed the significant weight gain on 12/23/24 the dietitian was not notified. During an interview on 12/24/24 at 11:48 A.M. Dietitian #210 stated when she reviewed Resident #43's weight on 12/20/24 she recognized a significant weight gain and requested a re-weigh. The facility obtained the new weight on 12/23/24. The dietitian stated once the re-weight was obtained on 12/23/24 she was not notified of the accuracy/confirmation that Resident #43 had a significant weight gain. Dietitian #210 stated she would have reviewed the new weight on 12/27/24 to determine if further interventions would be recommended. The dietitian stated she covered five homes and she was unable to review weights of all residents who might trigger for significant weight changes every day. The dietitian confirmed a better system of communication would be helpful for her to address significant weight changes in a more timely manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/26/24 at 1:21 P.M., Physician #260 verified she visited Resident #43 the day after her readmission from the hospital. Resident #43's discharge weight from the hospital was reviewed. It had been recorded as 320 pounds. No weight was available from the facility at that time. She believed the weight of 348.2 and 341.6 were inaccurate. The resident had been weighed via the wheelchair scale on her weights prior to discharge to the hospital. She assumed whoever weighed her did not use correct procedure. After being informed of the interview with the DON indicating both of the weights had been confirmed, Physician #260 reviewed documentation and stated after re-admission staff had weighed Resident #43 using the hoyer scale. A weight gain that large did not make sense as Resident 43 had received increased diuretics at the hospital and a gain of that amount without some physical signs would not make sense. In the hospital records it was documented the treatment was more palliative because diuresing with larger amounts of diuretics would cause a drop in blood pressure and affect her renal function. The physician indicated the hoyer scale probably needed recalculated. The physician indicated she had not yet discussed the weight or possible recalculation of the scale with the facility. The physician indicated although Resident #43 had a weight gain she believed, according to the hospital weight, no increase in weight monitoring was necessary. Review of the facility's Weight Assessment and Intervention policy (revised September 2008) indicated any weight change of 5% or more since the last weight assessment would be retaken the next day for confirmation. If the weight was verified, nursing would notify the dietitian. If the weight change was desirable, the information would be documented and no change in the care plan would be necessary. The dietitian was responsible for discussing undesired weight gain with the resident and/or family.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22653 Based on medical record review and interview, the facility failed to ensure a resident's significant weight loss was promptly investigated to determine if any additional nutritional interventions were necessary. This affected one (Resident #32) of three residents reviewed for nutrition. Findings include: Review of Resident #32's medical record revealed diagnoses including morbid obesity, type two diabetes mellitus, and vascular dementia. A plan of care initiated 11/05/23 indicated Resident #32 had a nutritional problem or potential nutritional problem related to diagnoses including diabetes mellitus, dementia, anemia, acute kidney failure, vitamin D deficiency, depression and hypertension and was on a therapeutic diet secondary to such. A goal initiated 11/05/23 indicated Resident #32 would maintain adequate nutritional status as evidenced by maintaining weight without significant change, no signs or symptoms of malnutrition, and consuming at least 75% of most meals daily. Gradual weight loss towards her ideal body weight range would be beneficial. An intervention initiated 01/31/23 indicated instructions to monitor/record/report signs and symptoms of malnutrition to the physician including significant weight loss of greater than 7.5% within three months. Another intervention initiated 01/31/23 indicated the dietitian was to evaluate and make diet change recommendations as necessary. A weight of 185.6 pounds was recorded in October 2024. No weight was recorded for November 2024. In December 2024 a weight of 171.2 pounds was recorded, representing a 7.76% loss in two months. A physician progress note for a visit made 12/07/24 indicated Resident #32 reported experiencing high blood sugar levels and weight loss which might be related to current medication regimen. Body weight was 171.2 pounds. Resident #32 had a history of morbid obesity and had decrease in weight. While weight loss was desired there was a concern about potential malnutrition. Interventions included continuing rybelsus (anti-diabetic medication) for weight management, monitoring weight regularly, and following up with prealbumin levels to assess nutritional status. A dietary note dated 12/13/24 at 8:39 A.M. revealed Resident #32 had experienced a 7.8% weight loss. A re-weigh was requested to verify the change. No further weights were recorded until staff were questioned about the dietitian's note on 12/23/24. On 12/24/24 at 6:00 A.M., the Director of Nursing (DON) stated she reviewed all weights. If she identified a discrepancy of more than five pounds since a previous weight, a resident was automatically re-weighed. The second weight was obtained before the information was entered into the electronic health record. The DON verified she had been unable to locate a weight obtained after the dietitian requested one on 12/13/24. At 6:22 A.M., the DON stated once the dietitian requested a re-weight the weight was expected to be obtained the following Monday. In this case the re-weight should have been obtained 12/16/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/24 at 11:48 A.M., Dietitian #210 stated the December weight was not put in the computer until 12/11/24. When she reviewed the weight on 12/13/24 she requested the resident be re-weighed. As of 12/23/24, she had not received a re-weight. Her expectation was to have the re-weights completed the Monday following the request. Because she managed nutritional assessments for residents in five different facilities, she was unable to reviewed all the weights for every facility on a daily basis and was reliant on staff drawing her attention to nutritional needs/significant weight changes. Otherwise, she had to wait until Friday when she reviewed the weights for the facility. Dietitian #210 could not explain how the lack of a new weight was not identified on 12/20/24 when she reviewed weights. During an interview with Physician #260 on 12/26/24 at 1:30 P.M. it was revealed some weight loss was expected related to the use of rybelsus. Physician #260 indicated she did plan on monitoring the prealbumin level but Resident #32 had refused the lab draws previously. Physician #260 stated she understood the concern of a weight loss being indicated on 12/05/24 which had not yet been addressed by the dietitian. Physician #260 stated she also understood the concern regarding Dietitian #210 recommending a re-weigh on 12/13/24 which had not been completed in a timely manner.